



PATIENT

Smores Quazi

SPECIES

canine

BREED

Yorkshire Terrier

SEX

MN

AGE

1 year

WEIGHT

4 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Catherine Alexander,
LVT

HOSPITAL NAME

North Star Veterinary
Sonography, PLLC

REFERRING VET

Dr. Sethi

INVOICE

11611

DATE

4/2/2026

PRESENTING CLINICAL SIGNS

Presenting for acute vomiting and soft stool with anorexia to mild hyporexia. Symptoms began Sunday with post-prandial vomiting (food present), continued Monday, progressed to anorexia and decreased energy Tuesday, with partial improvement Wednesday after treatment (resumed eating) and continued mild lethargy through Thursday. Water intake decreased. History of similar episode on 3/16 with daily bilious vomiting (yellow-green, midday 12–4 PM) that improved with omeprazole and supportive care. Intermittent GI sensitivity noted, including soft stool episodes and prior vomiting associated with monthly parasite prevention (Cuatro; last full dose 1/28/26, February dose vomited). No known toxin or foreign body exposure. Diet recently transitioned from Ziwi air-dried + canned (Weruva/Hills) to Hill's i/d (low fat GI diet). On exam QAR, mildly dehydrated (tacky MM), abdomen non-painful but mildly tense, rectal exam unremarkable with mixed hard to soft stool, T/AFAST negative for effusion or masses. HR noted on lower end at 84–90 bpm, no murmur auscultated. CBC/chem and fecal unremarkable. Treated with IV fluids, Cerenia (in-hospital and to-go), and Provable. Concern for recurrent GI signs; ultrasound requested to rule out structural disease (foreign material, gastritis/enteritis, pancreatitis, hepatobiliary disease, portosystemic shunt) vs functional disorder.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Prostate is normal in size, echotexture, and echogenicity for a neutered male.

The right kidney is normal is size (3.6 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (3.5 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The area of the right adrenal gland is examined without evident adrenal gland pathology but is unable to be well visualized/isolated for measurement.

The left adrenal gland is normal in size (0.37 cm at cranial pole and 0.33 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver



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The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing foreign material is considered less likely but cannot be definitively ruled out.

If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

Mucosal speckling -

The visible small intestines are normal in wall thickness and layering. Hyperechoic mucosal fogging or speckling is noted. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

Mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

ULTRASONOGRAPHIC FINDINGS

- Subtle/mild mucosal speckling – Mucosal speckling is often present with inflammatory bowel disease (IBD). It is not specific for type or severity of disease. Mild speckling change can occur as a normal patient variant in the post-prandial state. This appears to be a post-prandial study, which could be contributing to some mucosal speckling.
- Mildly reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely. This finding may be in part normal patient variant/juvenile lymphadenopathy given patient's young age.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There's not a definitive ultrasonographically visible intraabdominal explanation for patient's reported gastrointestinal signs, as the speckling is subtle/mild and the gastric contents appear consistent with normal ingesta. Having said that, non-shadowing non fully obstructive foreign material, while thought exceedingly less likely, cannot be definitively ruled out.

Further gastrointestinal workup recommendations include a routine fecal/giardia exam.

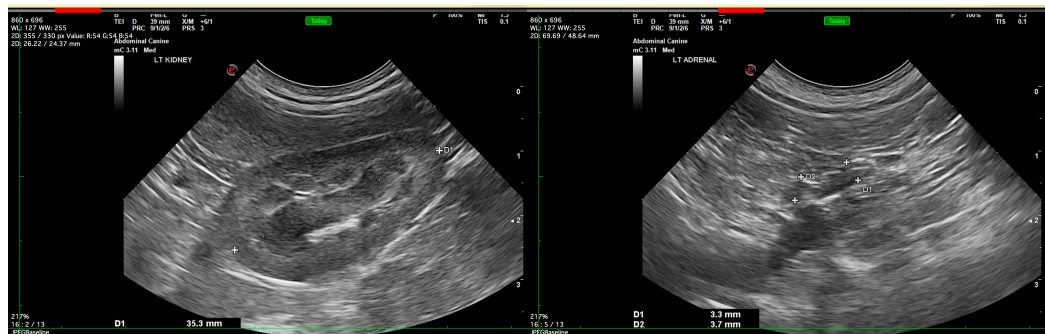
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

+/- A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

In the meantime:

- Supportive/symptomatic medical management of clinical signs is recommended, including anti-emetics, gastroprotectants (+/- sucralfate, especially with any history of hematemesis), an appetite stimulant and fluid therapy if indicated, etc.
- Additionally, empirical deworming with a 5-day course of Panacur is recommended.
- A full course of empirical Helicobacter triple therapy could be considered.
- A probiotic, such a visbiome or proviable, may be helpful.
- Finally, if tolerated, a transition in diet could be considered, based on trial-and-error response with some options to consider including a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs an easy to digest, bland or low-fat diet vs other.





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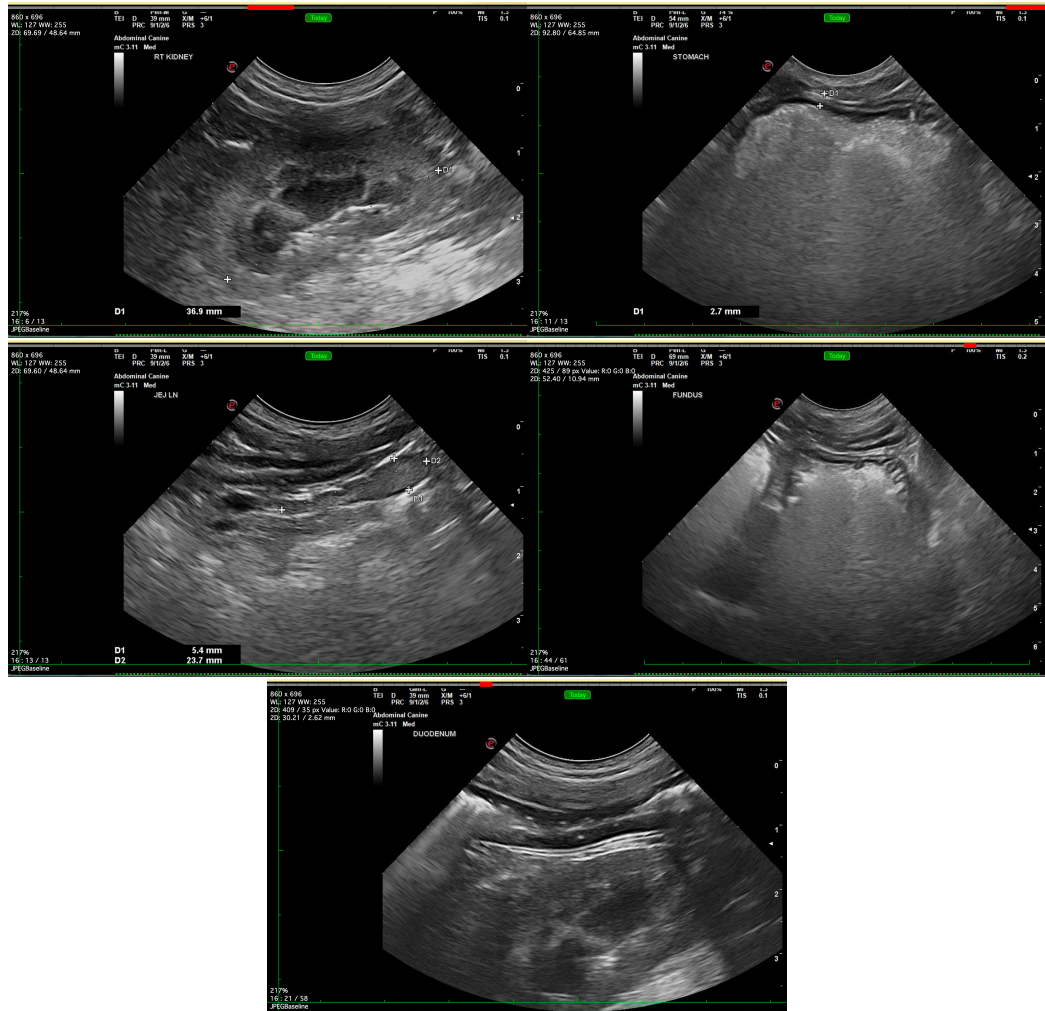
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Beth Johnson, DVM, DACVIM
info@sonopath.com